the local community college, receive scholarship assistance and college credit for college-level work completed in high school. In return, students must follow through on a pledge made in the 7th grade to graduate with a ''B'' average. Students in the program also agree to demonstrate leadership and other interpersonal skills, volunteer at school or in the community, and become technologically proficient. This is exactly the kind of jump-start this community needed to encourage students to complete their education and to ensure that recent graduates have the tools necessary to compete for today's high-paying jobs.

Each year, the number of students and volunteers involved in the World Class Scholars program continues to grow. But, perhaps of great mention, the number of other school districts participating throughout the county in collaboration with Grays Harbor Community College has also grown. In two years, the first class of high school students will graduate and the community's pledge to provide them with continued education will be honored. Clearly, Aberdeen and surrounding school districts have needs that are different, perhaps unique, from other localities throughout Washington state. They have met this problem head on and are well on the way to making their community a better place to live. The response of the Grays Harbor community perfectly demonstrates that local educators really do know best.

In presenting my Innovation in Education Awards, I fall back on this common-sense idea, that it is parents and educators the who look our children in the eye every day that know best how to educate them. For too long, the federal government has been telling local schools that Washington, DC bureaucrats know best. Educators across Washington state and throughout the country, like those involved in the World Class Scholars program, deserve more decision-making authority they deserve and I pledge to work hard to return that power to them.●

REMARKS BY DR. HENRY BUCHWALD

● Mr. HOLLINGS. Mr. President, I offer for the RECORD the text of a lecture delivered at the Central Surgical Association by Dr. Henry Buchwald, Professor of Surgery at the University of Minnesota. Dr. Buchwald, a past president of the association, is a highly regarded surgeon, and as we address Medicare reform and related matters in the months ahead, I believe we would do well to consider his words. At this time, I ask that excerpts of Dr. Henry Buchwald's presidential address be printed in the RECORD.

The material follows.

PRESIDENTIAL ADDRESS: A CLASH OF CULTURES—PERSONAL AUTONOMY VERSUS CORPORATE BONDAGE

(By Henry Buchwald, MD)

PERSONAL AUTONOMY

A constellation of principles embody the personality of the surgeon. At its core are the tradition and the ethos of personal autonomy. One of the distinguished past presidents of the Central Surgical Association, Donald Silver, who has been a role model for me, entitled his 1992 presidential address, ''Responsibilities and Rights.'' He allowed very few intrinsic rights to surgeons, but first among the limited prerogatives he granted was autonomy.

As surgeons, we tend to be individualists and to espouse individual responsibility. To us, maturity means being responsible for our actions. We keep our commitments. We view fiscal independence as essential. We take pride in earning a living and, should we have a family, in providing for its needs. To give the gift of an education to our children has been integral to our aspirations.

The years of medical school, residency, and the post-postgraduate education of clinical practice finally give birth to a surgeon. This individual has acquired a base of knowledge and the insight to apply facts and rational suppositions to the care of patients. This individual has obtained operating room skills secured by observation, trial and error, repetition, and respect for tissues and tissue planes and has learned the art of being gentle with a firm and steady hand. The surgeon has been sobered by death, by bad results, by the frustration of the inadequacies of even the most modern medical advances, and by the vagaries of human nature that obstruct the best of intentions and efforts. The surgeon has acknowledged fallibility and his or her power to do harm. The surgeon has become comfortable in a profession in which decisions are singular and responsibility is particular. The mature surgeon has achieved personal autonomy.

Within our company of surgeons we take just pride in our accomplishments. We are a distinct discipline with a unique body of knowledge. We are, for the most part, successful. We save lives, we increase life expectancy, we enhance the quality of existence. In addition, we have provided society with numerous competent surgical practitioners and built dynasties of surgical educators and researchers—individuals who bridge the present with the future of our profession.

Unfortunately, this golden age for surgery and the personal autonomy of the individual surgeon are threatened with imminent destruction by a force that will, if not countered and checked, lead us into corporate bondage. I will term this force administocracy.

CORPORATE BONDAGE

Ideally, the role of health care administration is to facilitate the work of physicians and health care personnel. But the chief administrators in our health care institutions and universities are no longer facilitators. They now seek to control. They have been redefining medical practice, clinics, academic departments, and universities on a corporate model, a model that subverts the essential nature of an intellectual society, a model totally alien to the definition of a university as a community.

Administocracy, the term I have coined to epitomize this force, is the rule of centralized administration, based on the top-down control of money, resources, and opportunities. Its primary beneficiaries are the administrative hierarchy. Administocracy has established itself as a new ruling class, an order clearly separated from the toilers in the vineyard of medicine. Administocracy is governance not by facilitation but by intimidation. Administocracy has gained or is gaining control of our medical schools, our teaching and community hospitals, and our current means of providing health care. I will outline administocracy's practices, codified into its own perverted Ten Commandments.

I: Thou shalt have no other system. The glory of our nation's democracy, the longest surviving democracy in the history of the world, is its ability to tolerate differences—to take new initiatives and then to retrench, to be liberal and to be conservative—and, concurrently, to be responsible to the will of the governed and to the precepts of fundamental code of principles and individual rights. An autocracy, on the other hand, denies flexibility and governance alternatives. An autocracy's overriding objective and only goal, regardless of any protestations of working for the common good, is its own perpetuation. By definition, such a system denies the will of the governed and refuses recognition of individual rights.

Administocracy is, of course, an autocracy. Once in power, administocracy's first order of business is to replicate itself. For example, in 1993 the academic administocracy at the University of Minnesota cut 435 civil service positions, while simultaneously adding 45 more executives and administrators.[1] The Office of the Senior Vice President for Health Sciences at Minnesota, a unit that did not even exist some years ago, now has 25 members.

The growth of medical administocracy is the result of genuine problems in the distribution of health care, including cost problems not adequately addressed by the medical profession itself. Our failure, or inability, to take action on these issues has allowed outsiders and opportunists within our own profession to hijack the delivery of health care. Among practicing physicians, a general ennui and a lack of resistance have been the reactions to the administocracies that are becoming our overlords. Perhaps one reason for this seeming complacency is that, individually, physicians feel powerless when faced with the well-organized, implacable machine of administocracy—an entity that knows its purpose and will use any means to attain its goals. Another reason is well expressed by Thurber's paraphrase of Lincoln: ''You can fool too many of the people too much of the time.''[2]

II: Thou shalt make new images. In his classic novel *1984*, Orwell beautifully illustrated the power of language and its willful distortion by governments. His use of ostensibly neutral words for disguising uncomforting realities set the standards for the current proliferation of Orwell's ''Newspeak.''[3] The medical and academic administocracies of today have devised their own Orwellian glossary of deception, often borrowing and redefining phrases from corporate industry and the military.

CEO, for chief executive officer, obviously comes from the corporate world. In academia and in hospital administration, it means a titular despot who controls the destiny and income of faculty and staff.

Reporting to and chain of command come from the military. These designations of caste and of obedience have not only been fully accepted by members of our profession but actually embraced and fostered by certain of our colleagues.

Executive management group means a cluster of deans.

Managed care is a euphemism for reducing patient services and physicians' fees to redistribute income to the ever-increasing number of administrators.

Utilization review stands for a bureaucratic sleight of hand to justify a predetermined reduction in patient services and health care personnel.

Market and consumer mean patient.

Market share means the number of patients you can hold hostage in a provider network.

Health care team means that the physician is only as essential to patient care as the multitude of people who stare into computers on nursing stations.

Vendor means you, the doctor.

II: Thou shalt take what is in vain: reengineer. Reengineering is the golden calf of administrocracy and takes in vain much of what we hold sacred. Reengineering would substitute dicta for scientific inquiry, the ''clean sheet'' for methodology, and assumptions for acquired knowledge. Reengineering has never been critically tested, certainly not in academia and hospital administration. No randomized clinical trials of reengineering have ever been conducted.

The definitions of reengineering are all quite similar. Michael Hammer and James Champy, two of the principal writers and consultants in the field, define it as follows: ''the fundamental rethinking and radical redesign of business processes, management systems, and structures of the business to achieve dramatic improvements in critical, contemporary measures of performance such as cost, quality service, and speed.'' [4]

The stages of reengineering are usually listed by its author advocates as preparing for change, planning for change, designing for change, implementing change, and evaluating change. Obviously, ''change'' is the key message, often spoken of as ''swift and radical change.'' Initiates to reengineering are instructed that it is essential to start this swift and radical change with the proverbial ''blank sheet of paper.'' Besides the logical fallacy of changing that which is blank, the sheet of paper is not blank; it contains our heritage. To start with a blank sheet means to erase the past. This concept of eliminating what we have painstakingly learned denies the most fundamental precept that we, as teachers, have passed on to generations of our students; namely, know the past and build on it. That way offers progress. Paul's First Epistle to the Thessalonians (5:21) states ''Prove all things; hold fast that which is good.''

If we do not learn from experience, from accumulated data and analyses, we will continually repeat history, and often bad history. Reengineering is a denial of the methodology of learned skills to deal with the business at hand, a denial of accumulated knowledge, a denial of the wisdom based on that knowledge. It is an abrogation of the scientific method.

In too much of the corporate-industrial world, reengineering has been the death blow to the company as family, a place to work with pride until retirement. In its place, reengineering has imposed the lean and mean corporate model of harsh downsizing—an organization devoid of workers' loyalty; characterized by a disregard for the customer in favor of the stockholder, plagued with a heavy load of debt, and ripe for a merger, conglomerate integration, and, eventually, extinction.

But enlightened industry has been abandoning reengineering, and the gurus of this nonsense have found it profitable to shift their expensive consultative services to academia and health care. Many of our associates have bitten hard into this apple of poisoned knowledge: Harvard, Tufts, Columbia, Cornell, Stanford, the University of California-San Francisco, Michigan, Henry Ford, and Minnesota are just some of the great institutions that have, to one degree or another, adopted reengineering. Physician-administrators, with little or no experience in the business world, are pushing hard to sell reengineering as a panacea for success and good fortune in the health sciences and in health care. They are huckstering a placebo.

The former provost of the University of Minnesota Academic Health Center and current president of Johns Hopkins, Dr. William R. Brody, brought the aforementioned James Champy to a University of Minnesota ''leadership retreat'' in July of 1995. At that meeting Mr. Champy, was quoted as saying: ''We live in debate . . . but you may have to exercise powers and say sometimes., 'The debate is over. This is the way we are going to be.' . . . visions are not built by groups . . . people in organizations want to be told what to do . . . There is a thirst for leadership, for top-down direction.'' [1]

Champy gave this advice pro bono. Eventually, however, his consulting firm, CSC Index, was paid $2.2 million by the University of Minnesota to put his philosophy into practice.[1]

Ever since the Brody mindset took hold of the university's administocracy, I have listened to speech after speech emphasizing that ''everything is on the table'' (freely translated to mean—tell us what you have so that we can take it away from you), and that the ultimate goal of reengineering was the ''reinvention of the academic health center.'' I was also present when straightforward questions about a prospective hospital merger were met with evasion and statements such as ''The negotiations are as yet too delicate to be openly discussed'' and ''I am not at liberty to provide these details.'' Only when the secret discussions had been concluded and the final decisions had already been made were faculty members informed of the swift and radical changes that would forever affect their lives and that these changes were ''non-negotiable.''

IV: Thou shalt keep horizontal integration holy. In the application of reengineering to academia and health care, the basic work unit is achieved by horizontal integration across disciplines. The medical community until recently has been discipline oriented. The change to horizontal integration represents a major paradigm shift. This change means that a patient would proceed not from one physician to other disciplinary specialists, as needed, but would be referred to a disease- or system-complex of physicians. This unit has been designated as a disease-based cluster, also called in various institutions a center, an institute, a service-line unit, and an interdisciplinary service program. The disease-based cluster is an imposition on patient care of management by a standing committee.

Contrary to the promises of the administocrats, life within the horizontally integrated unit is far from utopian. Because the income allocated to the unit by the administocrats is distributed by formula to the members of the disease-based cluster, the fewer members in the cluster, the more money for those who are retained. That formula encourages the urge to lighten ship. In this cluster, the members of the group have yielded the control of their practice and of their personal income to the group mentality. The surgeon is an employee of this group of primarily nonsurgeons, a fully salaried employee with few, if any, financial incentives.

Further, each cluster decides on the optimal time management for its employees. Economic unit pressure will limit the amount of time allocated for teaching and for research. If you want to teach, you will be told that extensive teaching is a luxury that the unit cannot afford for its surgeons. You will be told to limit your time with medical students and to limit the operating room time you offer residents, because this use of time does not serve the market-driven goals of your new workplace. Time spent in laboratory research by members of a clinical unit, especially the unit's surgeons, will be restricted or disallowed, because it would most assuredly decrease the unit's ability to compete in the clinical marketplace. Although the surgeon is the main stoker of the unit's economic furnace, decisions for the individual surgeon's distribution of time will no longer be at his or her discretion, but rather at the discretion of the economic will of the group. And, because the surgeon must spend an extensive amount of time in the operating room, the director of this disease-based cluster will, more than likely, not be a surgeon.

Where are the positive incentives for surgeons in the horizontally integrated unit? We have seen that the incentive is not in money, in teaching, or in research. Is it in the practice of our craft? Even that pleasure may not be allowed. Disease management in the cluster will be by what has been termed clinical pathways. This means surgery by the numbers; every surgeon will do the same procedure for a specific problem, in exactly the same manner, with a prescribed set of instructions for the use of nasogastric tubes, drains, antibiotics, alimentation, and so on. This assembly-line concept of surgery represents the ultimate destruction of the autonomy of the surgeon.

What will be left? The negative incentives of job security and the threat of punishment for expressions of individuality. Criteria for employment will be obedience to the group and a proper sense of beholdenness.

The emergence of horizontal integration in reengineered institutions is being vigorously proselytized by its advocates. Indeed, several plenary sessions at the 1997 meeting of the American College of Surgeons gave podium time to the leading proponents of horizontal integration, but none to its opponents. A more balanced analysis of this ''brave new world'' is needed. In the words of Aldous Huxley: ''Thought must be divided against itself before it can come to any knowledge of itself.'' [5]

V: Dishonor thy father and thy mother. The professional fathers and mothers of practicing doctors of medicine are the departments of the medical school. For use as surgeons, our professional parent is the department of surgery. Most of us have a strong allegiance to the departments that trained us and to those we now represent. We cite the teachings of our department as a justification for what we do and what we believe. We extol the achievements of the heroes of our department, and we have been known to contest between departments with fierce team loyalties. We tell departmental anecdotes into our dotage.

Historically, the strongest medical schools have had the most powerful departments. Feudalism may not have been an intellectual success in the Middle Ages, but it has been

the appropriate medical school governance system for our golden age of surgery. The independent department of surgery has, as a rule, been financially sound. It is able, therefore, to provide its faculty, in addition to a clinical practice, research opportunities, as well as the time to teach and to travel. The clinical atmosphere is exciting, allowing faculty to interact with questioning residents, and, through grand rounds and mortality and morbidity conferences, offering the best second opinions available anywhere. Independent departments gave birth to independent individuals, who had the imagination, innovative spirit, incentive, and drive to make surgery in the United States the best and the most envied in the world.

Reengineering would have us deny our departments, abandon them as mere relics. We are being told to dishonor our parental heritage and to deprive future generations of its nurturing. Horizontal integration is the death knell of the strong department of surgery as we know it. Independent departments that give rise to individualists are anathema to an administocracy, which would replace departmental parenting with the cloning of conformists.

The proponents of radical change are proposing that departments, for now, be maintained only for teaching students and lower levels of residents, and that their income will somehow be supplied by the dean of the medical school, to whom they will be indebted. The department chairs who will head these units will no longer be selected for scholarship, clinical acumen, and research accomplishments, but for administrative experience and political aspirations. As the lowest tier of the administocracy, they will not uphold or defend the department. In the future this system will eliminate clinical departments altogether, including their independent research, and delegate the teaching of the basic's of surgery to other than practicing surgeons.

VI: Thou shalt kill tenure. Tenure had its origins in the high Middle Ages and into the Reformation when royal edicts protected the person of the scholar and guaranteed safe passage.[6] As the university tradition developed on the continent and at Cambridge and Oxford, tenure became more of a fortification against the internal threat of dismissal at the pleasure of the clerical and political appointees who constituted the administration of these universities.[6]

In the 1990s, once again, tenure has become a highly charged controversy emerging from the academic cloister into the everyday world. Tenure is under attack in institutions of higher learning throughout the United States. This foundation of academic freedom, which includes the tenets of due process and freedom of expression, is being challenged as unwieldy and as an impediment to progress in today's fast-moving world and economy. It is seen as a barrier to effective top-down university administration. A lifelong commitment of appointment for faculty is being considered an unreasonable limit to a university's competitiveness. Tenure-track appointments per se are becoming more and more difficult to obtain, and the possibility of abolishing tenure is a current reality.

In the field of medicine we have traditionally not been strong advocates of the tenure system. Most surgeons, in and out of academia, have usually thought of tenure as the subterfuge of the weak and unaccomplished, the refuge of idlers and ne'er-do-wells. For my part, however, I am a strong proponent of tenure on principle and from experience. I have seen the University of Minnesota administocracy attempt to kill tenure. I have seen an outside consultant lawyer, hired by the Board of Regents, write a new tenure policy, subsequently put forth by the Board of Regents, that would have seriously restricted many aspects of academic freedom, denied due process, and allowed the disciplining of faculty for not having ''a proper attitude of industry and cooperation.'' I have seen the provost of the Academic Health Center become the leading opponent of tenure at the University of Minnesota and promise the state legislature to destroy tenure in exchange for increased funding for his personal vision of reengineering.

That threat to tenure has gone hand in hand with, and has served as the primary impetus for, unionization efforts by faculty, a turning to collective bargaining, the terminal polarization of a university into ''them'' and ''us.'' The union movement has been successful in some institutions and almost successful in others. We must recognize that the alternative before us is not between tenure or no tenure, but between tenure or membership in a trade union.

Centuries of reflection, turmoil, and hard-earned victories for freedom of expression within institutions of higher learning are embodied in tenure. That 1000-year-old legacy should not be swept aside by the know-nothing approach of ''reinventing the university.'' In the final analysis, tenure is the only protection that allows university faculty open criticism of the administocracy. Make no mistake about it, without tenure the outspoken individualists in the academic departments of surgery will be among the first to be fired for insubordination, for not having a proper attitude. They will be fired without due process and without the least concern for their productivity, hard work, loyalty, and demonstrable accomplishments. If not for tenure, many of our predecessors would not have survived to found and to sustain the Central Surgical Association. If not for tenure, many of us in this room would not be signing our names as professor of surgery.

VII: Thou shalt not commit to more than one career option. Once it was considered laudable in academia to pursue more than one career option—to be a researcher, a teacher, a consultant, as well as a practicing clinician. In the system of administocracy, such pursuits are adulterous, and they are prohibited. William Kelley, the apostle of linear career tracks, has made the laboratory doctors the highest order in the academic departmental hierarchy.[7] They follow a standard tenure track, spend little time with patients, and obtain their income from grants and from the efforts of their clinical-tract colleagues. Clinicians are confined, in turn, to patient activities, can have no laboratories, and may do only clinical research. Their primary job is to make the money needed by a two-track department. If these clinical doctors cannot keep up with the overall monetary demands, a third and fluid group of physicians, fresh out of residency, may be hired to see patients on a strict salary basis and to generate a sufficient overage of income to maintain the lifestyles of the nonclinicians.

Where does the double-threat, triple-threat, or even quadruple-threat academic surgeon of yesterday and today fit into such a system? He or she does not fit. Where is there allowance for the person who has honed his or her clinical judgment and operating room technique to achieve superb clinical outcomes and is also known as an eminent researcher, an outstanding teacher, and, possibly, an administrator-educator in the field of surgery? We may not find such renaissance individuals in the university of the first century of the third millennium. Those who exist today—many of them in this room—are the equivalents of the dinosaur. Honored today for their stature, their breed is destined for extinction.

VIII: Thou shalt steal. If the goal of administocracy is power, the means to achieve that goal is the control of money. For most of us, our incomes have been primarily derived from patient care on a fee-for-service basis. In the academic centers we ourselves allocated a percentage of our income to research, to resident education, to travel, and to departmental needs, as well as to paying a tithe to the dean. Currently, we are being forced to acquiesce to a seizure of our income at its source for redistribution outside of our control, consent, and often, knowledge. The imposition of layer upon layer of administrators and managers siphons off money to pay for their income, for the maintenance of their staff, and for the fulfillment of their, not our, aspirations. What finally trickles down to surgeons is a small fraction of the income we generate. In my opinion, this is theft.

The proliferation of health care provider organizations has given rise to a boom in building construction and occupancy to provide for the newly created health care managers. CEOs of managed care empires now take home millions of dollars annually. This is not capitalism but the embodiment of the Communist Manifesto: ''From each according to his abilities; to each according to his needs.''[8] Apparently, administocrats have the greatest needs. We have seen the advent of a plethora of executives, echelons of supervisors, authorizers of services, accountants, marketing and sales personnel, secretaries, telephone operators, and so on—all to do what we were able to do with a relatively minimal support staff. What feeds these engines of power? Fewer available patient services, less compensation for services, and an unparalleled redistribution of what we, the surgeons, earn. Whereas surgeons have a long and honorable history of providing care free of charge to the needy, the new system, through gatekeepers, restricts care for the needy and, through capitation, provides income to the greedy.

IX. Thou shalt bear false witness. The administocracy rewards or punishes faculty members in promotion and tenure proceedings, bestows awards and recognition, and grants institutional honors. The threat and implementation of both false-positive and false-negative witnessing are standard procedures in academic advancement and in the closure of academic careers. In certain institutions this method of control has extended to the misuse of the legal arm of central administration and the subversion of the internal judicial system of the university. Administocrats and their attorneys have made up rules as they go, with no basis for them in institutional regulations, the ''Calvin-ball''[9] approach to adjudication. For those who insist on believing that not all individuals in power can be corrupt and that decency at some level must still exist, I cite the words of 17th century aphorist, Jean de La Bruyère: ''Even the best-intentioned of great men need a few scoundrels around them; there are some things that you cannot ask an honest man to do.''[10]

X: Thou shalt covet. Finally, we come to coveting (Exodus 20:17): ''Thou shalt not covet thy neighbor's house, . . . nor anything that is thy neighbor's.''

The administocracy does indeed covet your ''house,'' because space is power. The personal space that you occupy outisde of the hospital and clinic, your office and your laboratory, is controlled by the administocracy. Allocation decisions are made not to facilitate your work and not as an incentive for productivity, but as a threat to achieve conformity and to guarantee compliance with their policies. When income is limited and proscribed, when the surgeon has become a 100% employee, then space and the use of that space become powerful inducements for faculty recruitment and retention. Space become a means to form a faculty to fit the new corporate mold. More than ever, space becomes a weapon to enforce compliance and to deny personal autonomy.

If money and space have been removed from the surgeon's control, how about the control of an individual's research? Here, too, administocracy has moved in. The formerly automatic forwarding of a properly prepared grant application has recently been subjected to additional internal institutional review and the threat of an institutional refusal to forward certain grant applications. This newly assumed institutional power has been termed a violation of academic freedom by a regional president of the American Association of University Professors.[1] Ongoing grants have been challenged by administocrats, with attempts at mandating personnel changes on a faculty research team. Faculty peer committees to supervise proper contract relations with industry have been disbanded and replaced by an administrator or a group subservient to the administocracy. Autonomy of research has been replaced by research at the pleasure of the administocracy.

There is, unfortunately, no limit to coveting. According to Horace: ''The covetous man is ever in want.'' [11]

RESOLUTION

Although I coined the term administocracy, all else in this version of the Ten Commandments, as perverted by this new corporate bondage, is based on what has happened, is happening, and will happen. For many of us, certain, if not all, of the forces and events outlined are already part of our personal histories. Those fortunate enough to have been spared thus far will not be so favored in the future. I hope no one in this audience suffers from ''mural dyslexia,'' [12] the inability to read the handwriting on the wall.

My intent in this narrative has been to express, in words and by examples, the manifestations of a calamitous reality that is altering the basic fabric of our professional lives, as well as the quality of medical care. We cannot elect simply to observe this transformation. The structures we stand on are disintegrating. If we continue to be complacent, if we do not oppose the powerful economic elements arrayed against us, if we take little interest in understanding the nature of our enemies, then surgery, as a discipline, and we, as surgeons and as independent practitioners, free to act within the boundaries of our conscience, will lose our culture, as well as our personal autonomy.

I have tried in these remarks to outline a brief differential diagnosis of this malady of encroaching administoracy, in order that we may formulate practical deterrents. I ask you to consider, each for your own situations, a workable, achievable alternative to administocracy, the forging of an ethical governance for academia, income distribution, and administration by facilitation. All of us need to take an active role in this process of evolution and innovation, to take it now, and to commit to it in the years to come.

Further, to maintain the individuality we prize, we have to realize that, individually, we are easy pickings. We must work together, as a community of surgeons, in our academic, cultural, and political organizations to defend our values. Ironic as it may be, we will need to give up some of our precious autonomy to safeguard that very autonomy. In his Republic, Plato expressed the concept of banding together as fundamental to preserving individualty: '' . . . a state comes into existence because no individual is self-sufficient. . . .'' [13]

A satisfactory resolution of this clash of cultures will not be achieved quickly or easily. This contest will not be decided by the sprinters. Victory will belong to the marathoners. Fortunately, surgeons are trained for the long haul.

CLOSURE

I would like to close with one final quotation, four questions of self-examination from the Talmud, which express my personal aspirations: ''Have I lived honorably on a daily basis? Have I raised the next generation? Have I set aside time for study? Have I lived hopefully? [14]

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RECOGNITION OF ACHIEVEMENT

● Mr. ASHCROFT. Mr. President, I rise today to extend appreciation to my spring 1999 class of interns: Lionel Thompson, Ryan Carney, Stephanie Harris, Kelly Owens, Daniel Lawson, Lacey Muhlfeld, Pete Johnson, Brian Kim, and J.Y. Brown. Each of these young people has served the people of Missouri diligently in my office. They have been invaluable members of my Operations Team over the past several months, and their efforts have not gone unnoticed.

Since I was elected in 1994, my staff and I have made an oath of service, commitment, and dedication. We dedicate ourselves to quality service. America's future will be determined by the character and productivity of our people. In this respect, we seek to lead by our example. We strive to lead with humility and honesty, and to work with energy and spirit. Our standard of productivity is accuracy, courtesy, efficiency, integrity, validity, and timeliness.

My spring interns have not only achieved this standard, but set a new standard on the tasks they were given. They exemplified a competitive level of work while maintaining a cooperative spirit. It is with much appreciation that I recognize Lionel, Ryan, Stephanie, Kelly, Daniel, Lacey, Pete, Brian, and J.Y. for their contribution to me and my staff in our effort to fulfill our office pledge and to serve all people by whose consent we govern.●

WORKERS' MEMORIAL DAY 1999

● Mr. FEINGOLD. Mr. President, I rise today to honor the men and women in our labor force that put their health and safety on the line every day at work. Today, we observe the passage of the landmark Occupational Safety and Health Act, signed into law 29 years ago, and the tenth anniversary of Workers' Memorial Day.

Mr. President, today is a chance for all of us to celebrate, and to mourn—to recognize the strides we've made on worker safety, and to mourn those who have lost their lives while they were simply doing their job.

Although the workplace death rate has been cut in half since 1970, 60,000 workers still die every year from job hazards, and six million more are injured. In Wisconsin our workplace accidents rate of 11.4 workplace accidents per 100 workers is higher than the national average. This is not a statistic anyone should be proud of, but it does help us maintain our focus as we work toward stronger laws, stricter enforcement, and safer workplaces.

We need to work together to protect the workers that have built our communities and helped them thrive. Unfortunately we still hear stories of workers like Vernon Langholff, who in 1993 fell 100 feet to his death when a corroded fire escape collapsed beneath him while he was cleaning dust from a grain bin. Just this year a company in Jefferson County was convicted in a state court for the recklessness that caused Langholff's death. In 1996 the company was fined $450,000 for its deliberate indifference to worker safety—because they delayed spending the $15,000 it would have taken to fix the